Counseling for Growth and Change, L.C.

Registration Information - Adult

SELF:

Name: _____ Today's Date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Date of Birth: _____ Age: _____ Soc. Sec. #: _____
Employer: _____ Occupation: _____
Employer Address: _____

Spouse/Partner:

Name _____ Age: _____ DOB: _____
Soc. Sec. #: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Employer Address: _____

Children(s) Name: _____ Age: ____DOB: _____ Sex: ___
Name: _____ Age: ____DOB: _____ Sex: ___
Name: _____ Age: ____DOB: _____ Sex: ___
Name: _____ Age: ____DOB: _____ Sex: ___
Name: _____ Age: ____DOB: _____ Sex: ___
Name: _____ Age: ____DOB: _____ Sex: ___

Emergency Contact Name, Phone and Relation:

_____
_____

Name of PCP/Location: _____
Medications/Dosages: _____
_____
Allergies: _____
Significant Medical Conditions: _____
_____

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Counseling for Growth and Change, L.C.

Assessment Information - Adult

PAYMENT INFORMATION

___ I will be personally responsible and privately paying for charges of therapeutic services.
___ I will be paying for therapeutic services with my insurance. (Please complete following information on insurance.).

INSURANCE (a copy of your card is required, please)

Primary Insurance Company Name:	Secondary Insurance Company Name (if any):
_____	_____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Birthdate: _____	Subscriber Birthdate: _____
Subscriber #: _____	Subscriber #: _____
Group #: _____	Group#: _____
Co-payment: $_____	Co-payment: $_____

INSURANCE PAYMENT AUTHORIZATION

I hereby direct my insurer to pay directly to Counseling for Growth & Change, LC., and/or my therapist all benefits due them as a result of claims for my therapeutic services. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be valid as the original.

Signature of Client: _____ Date: _____

INSURANCE RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Counseling for Growth & Change, LC., and/or my therapist to release information concerning my present illness to insurance carrier for the purpose of processing my claims. A photo static copy of this authorization will be valid as the original.

Signature of Client: _____ Date: _____

CANCELLATION POLICY

My therapist has reserved time to work with me, so I agree to contact this office 24 hours in advance of my scheduled appointment. Failure to provide such notice will result in a cancellation fee, and I understand I am responsible for payment of that fee.

Signature of Client: _____ Date: _____

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Counseling for Growth and Change, L.C.

Assessment Information - Adult

Name: _____ Today's Date: _____
Who referred you to this office? _____

Please place an "X" by the answer that is closest to describing your situation and/or fill in the blanks where necessary. Thank you.

1. Are you:
   _____ Single _____ Divorced
   _____ Married _____ Widowed
   _____ Separated _____ Co-habitating
   If you are living with someone, what is the quality of that relationship?
   _____ Good _____ Fair _____ Poor

2. Employed: _____ yes _____ no
   If yes, what is your occupation? _____

3. What problem(s) bring(s) you to counseling?
   _____ Depression _____ Grief
   _____ Family _____ Marital/Relationship
   _____ Job _____ Alcohol/drugs
   _____ Anxiety/Nervousness _____ Criminal charges
   _____ Stress Other: _____

   How severe is this problem(s)?___ Mild, ___ Moderate, ___ Severe, ___ Disabling
   How long has this problem(s) been troubling you? _____

4. Are you experiencing any of the following?
   _____ Guilt _____ Trouble Concentrating
   _____ Trouble sleeping _____ Panic/extremely nervous
   _____ Memory problems _____ Fatigue
   _____ Worry _____ Irritability
   _____ Poor appetite _____ Feeling hopeless
   _____ Loss of interest _____ Weight gain

5. Are you presently taking any medication? _____ Yes _____ No
   If yes, what kind? What dosage? For how long? _____
   _____

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6. Have you ever had any counseling before? _____ Yes _____ No
If yes, what for, where and when? _____

Have any of your family members had counseling before? ____ Yes ____ No
If yes, what for, where and when? _____

7. If you drink, would you describe yourself as being:
_____ a social drinker _____ a binge drinker
_____ a problem drinker _____ an alcoholic

Has anyone ever told you they thought you might have problem with alcohol?
_____ Yes _____ No

Have you ever had treatment for alcohol problems? _____ Yes _____ No
If yes, where and when? _____

8. If you use illicit drugs, would you describe yourself as being:
_____ a recreational user
_____ a problem user
_____ addicted

Has anyone ever told you they thought you might have a problem with prescription or illicit drugs? _____ Yes _____ No

Have you ever had treatment for prescription or illicit drug abuse? ___ Yes ___ No
If yes, where and when? _____

9. Do you have any relatives with a history of emotional, alcohol abuse, and/or prescription or illicit drug abuse? _____ Yes _____ No
If yes, who and what kind of problem? _____
_____

10. Do you presently have any involvement with the legal system? ___ Yes ___ No
If yes, what is it? _____
_____

11. Is there anything else about you that might be helpful to the counseling process?
_____
_____
_____
_____